MODULE 5 - NEWBORN DISCHARGE MODULE (TO BE FILLED OUT BY THE NURSE OR PHYSICIAN UPON DISCHARGE/TRANSFER/DEATH OF THE INFANT)						
1.	WAS THIS INFANT TRANSFERRED FROM	ANOTHER INSTITUTION?	2. DATE INFAN	T WAS TRANSFERF	RED IN	
	01 ☐ Yes 02 ☐ No				1 1	
3.	IF YES, TRANSFERRING FACILITY NAME A	AND LOCATION		Мо.	Day Yr.	
-						
	(Name)		ty/Town)	-	(County)	
4.	PROCEDURES/INTERVENTIONS (Check all					
	INFUSIONS 01 ☐ IV Antibiotics		ED VENTILATION Oxygen Therapy			
	02 Blood Transfusion		0A. Duration	Days		
	03 Exchange Transfusion	11 🗆		Dayo		
	04 ☐ Parenteral Alimentation 05 ☐ Ototoxic Drugs (Mult/Combination)		1A. Duration	Days		
	_	12 🗆	Mechanical Ventilation			
	SURGERY 06   Circumcision		2A. Duration	Days		
	07 ☐ Other Surgery	OTHER	FOMO			
	CATHETERIZATIONS		ECMO Phototherapy			
	08 ☐ Umbilical Artery Catheterization		Surfactant Therapy			
	09 ☐ Umbilical Vein Catheterization		Other, Specify:			
		00 🗆				
5.	DIAGNOSIS OF INFANT (Conditions occurring any time prior to discharge) (Check all that apply)					
	01 ☐ Normal Newborn RESPIRATORY 02 ☐ Abnormal Neurologic Exam 17 ☐ Home Monitoring					
	NEUROLOGIC	18 🗆	•			
	03 ☐ Seizures	19 🗖	Meconium Aspiration S	Syndrome		
	04 ☐ Central Nervous System Hemorrhage		Pneumonia			
	05 ☐ Palsy 06 ☐ Brachioplexis Injury		Air Leak Syndrome Home on Oxygen			
	CONGENITAL MALFORMATION		RDS/HMD			
	07 ☐ Reportable Birth Defect	24 Transient Tachypnea of Newborn				
	HEMATOLOGIC DISEASE 25 ☐ Persistent Pulmonary Hypertension  08 ☐ Coombs Positive MISCELLANEOUS					
	09 ☐ RH Hemolytic		Drug Dependency			
	10 ☐ Hyperbilirubinemia 27 ☐ Fetal Alcohol Syndrome					
	11 ☐ Polycythemia (Venous Hct >65) 12 ☐ Other Hematologic	28 ☐ Fracture/Dislocation 29 ☐ Necrotizing Enterocolitis 30 ☐ Cephalic Molding				
	INFECTIOUS DISEASE					
	13 ☐ Meningitis (Bacterial/Viral)	31 ☐ Symptomatic Hypoglycemia + Glu <20				
	14 ☐ Proven Sepsis 15 ☐ In Utero Infection (TORCH)	_	Stigmata/Anomalies As	ssociated with Hearing	Loss	
	16 ☐ Syphilis Serology Positive	33 🗖	Other, Specify:			
6.		7. OAE FAILED?		8. ABR/BAER FA	AILED?	
	01 ☐ Yes 02 ☐ No	01 ☐ Yes	02 🔲 No	01 ☐ Yes	02	
9.	HEPATITIS B VACCINE GIVEN?	IF YES, DATE:		10. HEPATITIS B	IMMUNOGLOBULIN DATE	
	01 ☐ Yes 02 ☐ No	,	1		1 1	
		Mo. L	Day Yr.	Mo.	Day Yr.	
11.	FEEDING AT DISCHARGE (Check one)					
	01 Breast Feeding 02 Formula 03 Combination 04 Other					
12	NICU DISPOSITION FOR THIS NEWBORN					
	01 ☐ Admitted to an NICU in this hospital	02  Not admitted to an	NICU 03 [	☐ Transferred to an N	ICU in another hospital	
13.	NICU ADMISSION DATE	14.	NICU DISCHARGE	DATE		
	/	1			/	
45	Mo. Day	y Yr.		Мо.	Day Yr.	
	15. WAS THIS CHILD ADMITTED TO AN INTERMEDIATE CARE UNIT DURING THIS STAY? 01 ☐ Yes 02 ☐ No					
16.	FINAL STATUS OF INFANT	17. DATE OF DI   TRANSFER	SCHARGE, DEATH (		DISCHARGE, DEATH OR	
					□AM	
	03 Died	1	1		: □PM	
	04 ☐ Other, Specify:	Mo.	Day Yr.			
-10						
19. IF TRANSFERRED, RECEIVING INSTITUTION						
-	(Name)		ty/Town)		(County)	
Nam	ne of Individual Completing This Module	Signature	y/ I UWII)		Date	
	. •	Ĭ				
		l				

REG-4 DEC 02 5